this issue on "LPS and the Mental Health Center," provide impressive data showing that the principles inherent in the Lanterman-Petris-Short legislation led to marked reductions in admissions to state mental hospitals and to reductions in the duration of stay in hospital. (They wisely point out, however, that systematic, long-term evaluation of such a shift in therapeutic orientation is yet to be carried out.) Concomitantly, the use of outpatient services increased, although whether by patients in after-care, by types of patients formerly hospitalized, or by tapping a pool of patients not seen before is not clarified. Involuntary inpatient admissions decreased decidedly, and the great majority of them were for periods of three days or less.

There is no unanimity among psychiatrists that the community mental health movement is necessarily the best approach to meeting the need for better delivery of mental health services. It has been described as "wholesale psychiatry," and serious questions have been raised as to the quality of services provided to individual patients. Some have decried the apparent denigration of the one-to-one doctor-patient relationship and have regarded the community mental health approach as superficial. We do not know, as yet, that the shorter the stay in hospital the better, or that eliminating or reducing the period of hospital treatment will save money in the long run.

Some psychiatrists feel that with short periods in hospital and early discharge to the community, patients do not have sufficient time to work through to the solution of the acute problems that led to their admission, and that, as a result, readmission rates are considerably higher. Moreover, many problems require the resolution of intrafamily and interpersonal tensions, and this takes time. Few studies have evaluated the burden placed on patients' families when patients are kept within the family group despite evidence of overt psychopathologic and behavioral problems.[3,4] It frequently is necessary to make appropriate referral to agencies and physicians for continued treatment, and such plans often require more than a few days to implement.

However, the proponents of short hospital stay insist that hospital treatment should be used only for the rapid resolution of crisis situations and then only when absolutely necessary; other problems can be worked out on an ambulatory basis.[5] If repeated admissions are required, this is still better than long periods in hospital that may well induce exaggeration of dependency problems and interfere with adequate social rehabilitation. The community mental health concept, according to this view, has as its goal social rehabilitation rather than primarily the resolution of psychodynamic conflicts.

The fact remains that the mental hospital population in the United States has fallen from a little more than 500,000 ten years ago to less than 400,000 now, and in California from 36,853 to 12,671. The rapid development of the community mental health movement throughout the country has played a significant role in this reduction. Psychiatry points with pride to this accomplishment.

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The 100th Annual Scientific Assembly

IN THIS ISSUE is to be found the program of the 100th Annual Scientific Assembly. This centennial assembly reminds us that even after a hundred years of growth and change a basic purpose of the CMA is still "to promote the science and art of medicine." The program developed by John Dillon and his Committee on Scientific Assemblies reflects the enormous scope of medicine's scientific interest as it exists today. Come to Anaheim. It will be worth it. And you can take in Disneyland too.